MC0132

HOSPITAL BUILDING NOTE

ACCOMMODATION FOR PSYCHIATRIC PATIENTS

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Accommodation for Psychiatric Patients

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I. Scope

1. This Building Note gives general advice on the planning of hospital accommodation for psychiatric patients of different types. Detailed advice on the planning of the buildings which will be needed will be given in other Notes. Building Note No. 5 dealing with short-stay psychiatric units without rehabilitation facilities has already been issued.

2. The phrase " psychiatric patients " is used to refer to patients suffering from all forms of mental disorder. " Psychiatric hospital " is used similarly. The general remarks in paragraphs 4-10 describe the requirements for the mentally ill; the needs of the mentally subnormal are discussed in paragraph 11. Owing to the different Acts on which provision for the care of the mentally ill is based, this Building Note should not be regarded as applying to Scotland.

II. General considerations

3. This Note distinguishes the following groups of patients:

(*a*) Mentally ill needing intensive treatment for the relief of symptoms. Their stay in hospital is not usually more than 3 months.

(*b*) Mentally ill needing rehabilitation (usually following a period of intensive treatment) whose stay in hospital is not more than about 6 months.

(*c*) Mentally ill, long stay, who are in hospital for more than 6 months.
(*Note:* These figures of duration of stay are only a guide and should not be too rigidly interpreted.)

(*d*) Severely subnormal, low-grade.

(*e*) Severely subnormal, medium-grade.

(*f*) Subnormal, low-grade.

(*g*) Subnormal, high-grade.

(*h*) Psychopathic.

(*i*) Patients suffering from any type of mental disorder who require treatment under security conditions.

(*j*) Certain small definable groups—e.g. psychotic children and adolescents, alcoholics—for which special provision is needed.
(*Note:* The terms " severe subnormality " and " subnormality " as used here correspond closely, but not necessarily exactly, to the definitions contained in the Mental Health Act. For example, a patient who, for the purposes of the Act, has been classified as suffering from severe subnormality, might for treatment purposes be regarded as falling within group (*f*); similarly, a few patients classified as suffering from subnormality might, for treatment, come within group (*e*).)

Mentally ill patients

4. For historical reasons, most psychiatric patients have, until fairly recently, been treated in hospitals entirely divorced from the rest of the hospital service. This reflected the extent to which it was possible to offer effective treatment. That position has now changed. Psychiatry is becoming absorbed into the main stream of medicine, to the advantage of both, and hospitals for the mentally ill have become centres of therapeutic effort and rehabilitation instead of being mainly custodial. These vitally important changes must be reflected in the future planning of hospital psychiatric services.

5. The custodial aspects of the work of hospitals for the mentally ill, though they continue to exist for a minority of patients, are now much less important, and the main object is to persuade patients to accept treatment and to offer it under such conditions that normal social relationships will be as little disturbed as possible. It is therefore now quite wrong to plan for large, isolated hospitals, or to make the psychiatric services anything other than an integral part of the hospital service as a whole.

6. Isolation is wrong because it cuts patients off from social links; for example, it makes visiting difficult. Wherever possible, mentally ill patients should be able to use all the normal social amenities —shops, cinemas, playing fields, and so on—and for a proportion of them (especially those whose stay in hospital has been prolonged) proximity to employment, which they can undertake while remaining in hospital, is important. Isolation is also wrong because it will almost inevitably make it more difficult for patients to seek and obtain treatment at an early stage, and because it may tend to delay the complete integration of psychiatry with the rest of medicine and to impede co-operation with the community mental health services.

7. Isolation makes recruitment of staff more difficult. Fewer beds for the mentally ill will in future be needed, but this will not lead to a reduction in the demaind for trained staff. Thus it is important that, in planning accommodation, Boards should not hamper themselves unnecessarily in the matter of recruitment by bad siting. The need to interchange and share staff between different types of mentally ill patients must also be borne in mind when siting is under consideration, since these are important means of combating any misconceived impression that work with longer-stay patients is in some way inferior. It is necessary that there should be a scheme of classification designed to secure continuity of care; and if such a scheme is to be successful, each therapeutic team should be responsible for the treatment of a complete cross-section of patients, in whatever accommodation they may be. This means that medical teams should be responsible for both short- and long-stay beds, and the nursing staff should do periods of service in each section. Such a scheme is necessary for training purposes: and it would ensure that proper attention is paid to the longer-stay patients.

8. In siting hospital accommodation for the mentally ill attention should be paid to the following principles. First, it should be placed as centrally as possible in relation to the population it serves; and secondly, neither the population served nor the catchment area should be too great. Thirdly, hospital facilities for the mentally ill should be closely associated with those for the other branches of medicine.

9. The amount of accommodation provided will be governed by the size of the population to be served. In urban areas a population of 250,000 will normally be a suitable upper limit but the size and population of the area served by the local health authority should also be taken into account. Three important advantages of a limited catchment area and central siting are, first, that patients are better able to preserve their community ties; secondly, that links with the local authority and Ministry of Labour services, which are of such major importance, will be easier to form and maintain; and thirdly, that the size of the units themselves will not need to be too large. One of the main defects of many old style mental hospitals is their excessive size which leads to difficulties in medical administration and has encouraged institutionalisation.

10. Some existing hospitals for the mentally ill can suitably continue in long term use, if necessary after redevelopment, so long as they are structurally suitable and are well sited; but there are many to which this will not apply and certainly the largest, oldest and most isolated of them ought to be abandoned at the earliest opportunity.

Subnormal patients

11. Very similar trends have affected hospitals for the mentally subnormal. There has been a considerable increase in the level of therapeutic activity and the relative importance of their purely custodial duties has consequently declined. Much emphasis is now placed on efforts to return patients to normal life or to conditions approximating to normal life, and the objections to isolation are therefore strong, for broadly the same reasons as apply to mentally ill patients. Isolation should also be avoided because of the harmful effects it may have on staff recruitment. This is an important consideration because the indications are that the number of beds —and hence the number of staff—needed in hospitals for the mentally subnormal will tend to increase. When siting is being considered, the great importance of maintaining close contact with paediatricians and easy access to educational facilities must also be borne in mind. It is desirable that the catchment area served by a hospital for the mentally subnormal should not be too large; as with the mentally ill, this will enable patients to preserve their ties with the community and will help the hospital to maintain close co-operation with the community mental health services. It will also make it possible to avoid unduly large hospitals, which is a matter of importance for the mentally subnormal as well as for the mentally ill.

III. The hospital needs of individual groups of patients

A. Number of beds required for mentally ill patients

12. As explained in paragraph 17 of the Hospital Plan (Cmnd. 1604) it is estimated that by 1975 only 1.8 beds per 1,000 population will be needed for the treatment of mental illness. Roughly half the beds will be needed for patients whose stay in hospital exceeds 2 years. These figures are, however, based on practice in 1954/56 and variations from them are therefore to be expected as a result of therapeutic advances, changes in the age structure of the population, improvements in community mental health services, etc.

Mentally ill patients needing intensive treatment

13. These patients, whose length of stay will not normally exceed three months, need treatment in fairly small units situated as near as possible to their homes. Such units, in conjunction with which out-patient and day patient facilities should be provided, should generally be situated at district general or teaching hospitals, though they can also be at mental hospitals if the latter are suitable and well sited. They should usually contain at least 60 beds. Facilities for rehabilitation will be required. The siting and content of facilities for these patients will

be dealt with in a revised edition of Building Note No. 5, 'Short-stay Psychiatric Unit'.

Mentally ill patients needing short-term rehabilitation

14. These are mentally ill patients who, often after a period of intensive treatment, require rehabilitation, but whose stay in hospital does not exceed about six months. They need treatment in units comprising an intensive treatment section on the lines described in paragraph 13, together with about 100 additional beds for rehabilitation. Workshops and facilities for indoor recreation are essential, and should be large enough to accommodate in addition an appreciable number of day patients. Such units can in many cases best be situated within the curtilage of a district general hospital.

Mentally ill patients, long stay

15. Advice about the facilities needed by these patients will be given at a later date when more detailed information about their probable future numbers and nature has been obtained and analysed. For the time being, they will generally be accommodated in existing mental hospitals.

B. Number of beds required for subnormal and severely subnormal patients

16. There is at present a substantial unsatisfied demand in all regions for beds for subnormal and severely subnormal patients. This is shown by the existence of long waiting-lists for admission to hospitals and of substantial, though variable, overcrowding. It is very difficult to estimate future trends, but there seems no reason for supposing that there will in the immediate future be any considerable reduction in the demand for beds. On the contrary, lengthened expectation of life, together with an apparently increased willingness of parents for their children to be admitted to hospital (perhaps due to the enhanced reputation of the hospitals and to the effect of the introduction of informal admission) are tending to increase pressure. In the long run, however, it seems clear that the development of the community mental health services will remove some of the burden from the hospitals. This will probably come through a reduction in the number of admissions to hospitals (or at any rate to a postponement of the time when admission is necessary) rather than by the transfer of large numbers of existing patients to hostels run by local authorities. In the present state of affairs, it may seem unnecessary to sound a warning against the over-provision of hospital accommodation for subnormal or severely subnormal patients. Despite the immediate need, however, this is a long-term possibility which should not be overlooked. It is therefore important that, in preparing future plans, hospital authorities should co-operate with local health authorities and should know what plans they have in mind for the future growth of the community services. Co-ordination in the planning of these two parts of the National Health Service is of particular importance.

17. In many hospitals there has already been a marked tendency for the proportion of severely subnormal patients to increase compared with subnormal patients. It is likely that one important cause is the growth of the community services for subnormal patients and that the trend will continue and intensify as the development of the community services proceeds.

Low-grade severely subnormal patients

18. Many of these patients will be suffering from physical as well as mental handicaps. Few, if any, will become fit for discharge from hospital to home care.

19. The infants and children in this category require nursing, medical and neurosurgical attention rather than psychiatric treatment. Therefore they need not, though they can, be accommodated in a hospital for the severely subnormal. Whether they are ambulant or not they should have space and equipment for exercise and play, and their unit should be readily available for visiting.

20. The adolescents and adults, some of whom will not be ambulant, require more specialised nursing care and should be in a hospital for the severely subnormal. Because their intellectual functions cannot develop their needs remain basically those of children.

Medium-grade severely subnormal patients

21. Most of these patients will be ambulant and will require training in personal hygiene and work; recreation both indoor and outdoor will also be needed. Some of these patients may graduate to sheltered work outside the hospital but many will need permanent care in hospital.

Low-grade subnormal patients

22. Most of these patients come into hospital because they are emotionally unstable as well as intellectually backward (I.Qs. around the 50-60 level). The object of treatment is to correct the instability. The training consists of regular routine work which is often of an industrial nature. As patients in this group become stabilised they re-enter the community via local authority hostels and guardianship.

(*Note:* Among the patients in the above three categories there may be a few who require treatment under security conditions. The best solution may be to establish one or two self-contained secure units at suitable hospitals in the region, and to admit to them suitable patients from all parts of the region—see paragraph 32.)

23. Low and medium-grade severely subnormal and low-grade subnormal patients should be treated

in separate units, which may be part of a single hospital for the subnormal. A single hospital should have not more than about 500 beds.

High-grade subnormal patients

24. Intellectual backwardness, often coupled with minor physical handicaps is a common background for emotional instability. Psychiatric attention is often needed both for diagnosis and assessment and sometimes for psychotherapy and vocational training. Some of these patients will need the therapeutic régime of a hospital for the subnormal; others will be classified as psychopaths, and a third group with clearly defined psychotic or neurotic disturbances will qualify for a period of treatment in a unit for the mentally ill.

25. If provision is made for such patients in hospitals for the subnormal it should be separate from the rest of the hospital (although drawing from its basic services, e.g. food, stores, etc.) so that they do not have to mix with the more severely handicapped patients. Some accommodation may be needed of a type suitable for patients who go out to local work as a preliminary to returning fully to the community.

C. Psychopathic patients

26. Although there is no entirely satisfactory medical definition of psychopathy, this numerically small group of patients is easily recognised. The defect of personality, often constitutional, that characterises such patients may be associated with high, normal, or subnormal intelligence, but the disorder invariably limits the effective use of the intellectual faculties that are necessary for harmonious social relationships. For this reason some, but by no means all, psychopaths exhibit serious and persistent anti-social behaviour which necessitates their investigation and treatment apart from other patients and in a security setting.

27. In the past, psychopaths of all but the most violent types were accepted for treatment in mental and mental deficiency hospitals, and this will doubtless continue. For though special arrangements may be needed for their thorough scientific investigation, their treatment by psychotherapy and disciplined training should be within the scope of either type of psychiatric hospital.

28. Some psychopaths are likely to present a security problem with which an open hospital would find it difficult to cope. Such patients will require special accommodation, the design of which will initially be experimental, and will vary according to the kind of treatment that it is intended to give. Since treatment is likely to be lengthy, in some cases facilities for regular work and recreation will be needed and some degree of security will have to be provided.

D. Patients who require security

29. Some patients need to be treated under security conditions for their own protection or that of others. They may be suffering from any form of mental disorder, i.e. mental illness, mental subnormality or psychopathic disorder.

30. First, there are patients who need security only temporarily—for example, mentally ill patients admitted to hospital in emergency who may be violent for a short time. All psychiatric hospitals will normally reckon to deal with such patients as part of their day-to-day work. The necessary security arrangements can be provided by, for example, using a suitable single room and providing thorough supervision.

31. Secondly, there are patients who need security arrangements on a long term basis but do not require to be admitted to a special hospital. The exact arrangements which should be made for such patients will be determined by local circumstances. Sometimes all that is needed will be a locked ward or wards in a psychiatric hospital, the patients using the recreational and occupational facilities of the hospital along with the other patients; security will then take the form of locked doors in the ward and protection to the windows. For the rest, security will depend on close supervision, which implies that staff should be adequate in number and conscious of the importance of security. Plentiful facilities for occupation and recreation are also needed. In wards which are to be locked, it may be thought advisable to provide a rather higher proportion of single rooms. In some of these, windows might be provided with armoured glass and doors might be made to open outwards and be fitted with a glazed observation panel.

32. A more convenient course, and one more likely to enable medium security to be maintained effectively, is probably the establishment in each region of a small number of security units, separate provision being made for mentally ill and for other types of psychiatric patients. Such units will usually need to provide their own occupational and recreational facilities so as to make them self-sufficient, and it may be desirable to surround them with a fence or wall. The remarks made above would apply to the buildings forming part of such a unit. In general, one would expect that suitable adaptations could be made to parts of existing psychiatric hospitals, many of which were until fairly recently accustomed to giving treatment under security conditions. Some patients classified as suffering from psychopathic disorder will no doubt be accommodated in such units; others will be in the accommodation for psychopathic patients mentioned in paragraph 28.

E. Special groups

33. Advice has already been given about units for the treatment of alcoholism—see HM(62)43 on Hospital Treatment of Alcoholism. The question of the provision which should be made for psychotic children and adolescents is at present under consideration, and it is hoped to issue advice on the subject.

IV. Priorities

34. It is accepted that in many regions there is a need, sometimes an urgent one, for more hospital provision for subnormal and severely subnormal patients. Boards may wish to give high priority to some building projects designed to meet this need.

35. The need for out-patient and day patient facilities for the mentally ill, and also for suitably sited short-stay beds, is also established beyond any reasonable doubt, and provision of this type is a matter of urgency. Guidance will be included in a revise of Building Note No. 5.

36. As regards long-stay patients, the position is much less clear. As explained in paragraph 16, most of them are now in existing mental hospitals, and capital works may have to be undertaken so as to upgrade their living conditions or improve the opportunities for their rehabilitation. Generally, however, it will be unwise to embark on the large-scale reconstruction of existing mental hospitals, unless they are well situated and are clearly going to be needed throughout the foreseeable future, since this might in effect produce a commitment to preserve a pattern which will before long become outmoded.

V. General planning

37. The provision of accommodation for psychiatric patients will follow from decisions taken in the different stages of planning. They will include examination of the following:

(i) Numbers and types of patients related to the catchment area.

(ii) Sites available (including adaptation of existing buildings) in or adjacent to district general, or psychiatric hospitals.

(iii) The range of requirements on each site for treatment, rehabilitation, and social amenities.

(iv) Information on the requirements for individual buildings and the capabilities of those buildings for use or adaptation to patient needs.

(v) Provision for change in numbers of patients and treatment methods in the accommodation.

38. General principles of layout, adaptability, use of site, etc., will be dealt with in this Note. Further Notes will be issued dealing with accommodation for specific patient groups.

39. The design of all patient accommodation (for both mentally ill and subnormal) should make allowances for changes in use from time to time. This is possible because the demands of one group are often similar to those of other groups. For example, space and fitting-out requirements are broadly comparable for patients within each of the following groups:

non-ambulant patients—various classifications

ambulant patients—requiring intensive treatment or rehabilitation

ambulant patients—requiring long-term rehabilitation with some supervision

ambulant patients—little or no supervision

In this and subsequent Building Notes where accommodation is described as suitable for specified patients, its suitability for others is not, therefore, precluded, for example one design of training room may well be suitable for all types of mentally ill patients and for all ambulant subnormal patients. Again, it may be found that the design of accommodation for a rehabilitation, work, and social centre for subnormal patients, may also be suitable for some of the larger existing hospitals for the mentally ill. When more information on the needs of all patients is available the full adaptability of the current proposals on accommodation will be reassessed and adjusted if necessary with a view to making them more generally applicable to the broad patient groups listed above.

40. Guidance on the design of accommodation for longer term rehabilitation patients will not be made until more detailed information is available on their needs.

Accommodation at a parent hospital

41. Intensive treatment and rehabilitation units for mentally ill patients will normally be required at district general hospitals or at those psychiatric hospitals which are suitably placed in the community. Broadly speaking they should be sited so that they can share the services and amenities of the parent hospital while still preserving a separate identity. This planning requirement will need particular attention where links with an out-patient department at a district general hospital are involved and when provision for day patients is required. The comprehensive design requirements of such units will be described in a revised version of Building Note No. 5, to be published shortly.

Separate (self-contained) psychiatric hospitals

42. Self-contained hospitals will be required for mentally subnormal patients. Such hospitals will usually be made up of groups of buildings predominantly single or double storied, with a general layout comparable to that of a compact village or urban neighbourhood. An upper limit of 500 beds is envisaged which will accommodate a variety of grades of patients.

43. Eight main types of accommodation will be required:

(i) In-patient wards

(ii) Rehabilitation, training, and work rooms

(iii) Social and recreational facilities

(iv) Medical facilities

(v) Administrative offices

(vi) Supplies, stores, kitchen, etc.

(vii) Hospital engineering and works facilities

(viii) Staff residential accommodation

44. Types (v), (vi), (vii) and (viii) refer to accommodation which need not be related only to psychiatric hospitals and design guidance is given in Building Notes for district general hospitals. Likewise the limited amount of accommodation needed for type (iv) may be adapted for psychiatric hospital use from equivalent accommodation found in district general hospital out-patient departments. Isolation wards may sometimes be necessary and occasionally laboratory units may also be required in those hospitals selected for research or special treatment (though this can often be carried out in the paediatric department of a convenient general hospital).

45. The function of the hospital as a whole will determine the general disposition of the various types of accommodation within it. Certain services (e.g. food and patient rehabilitation) should be within easy reach of the whole hospital and so are best sited centrally. On the other hand groups of ward accommodation and also the staff residential area can with advantage be in peripheral zones. Broadly the functional zones of activity within the hospital can be described as follows:

Central core with access from approach road to hospital and links with all parts within the hospital.	Main entrance, administration, and staff rooms, supplies, stores, services, kitchen, etc.
Communal facilities with links to particular activities from all parts of the hospital.	Rehabilitation, work and social centres, sports and recreational facilities.
In-patient ward accommodation individual environmental treatment of buildings to separate groups of patients from each other, but providing each with convenient access to the communal facilities and central core.	Various types of wards.
Children's accommodation separate from all adult activities but with access to the central core.	Wards, training rooms (school), play areas.

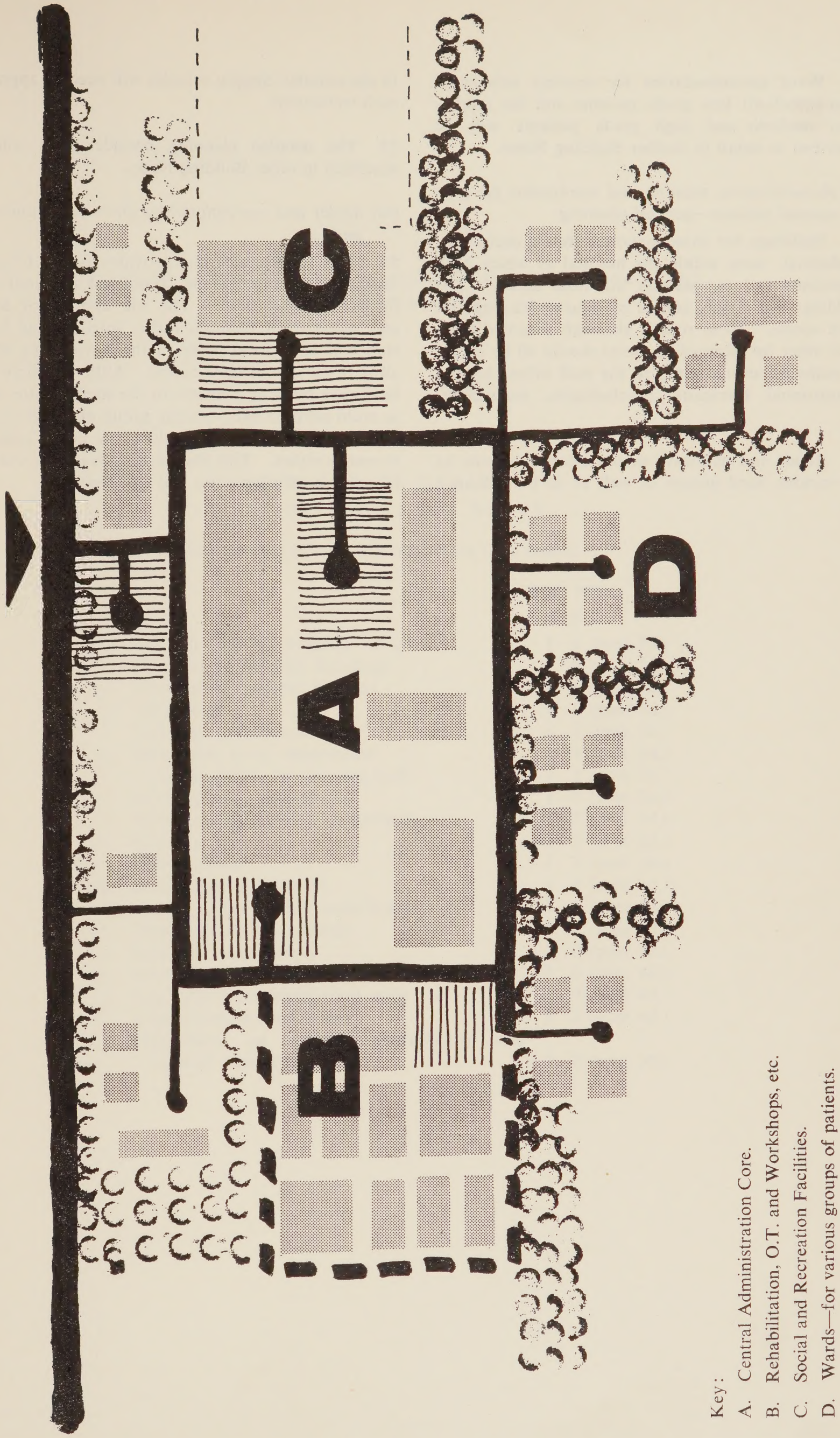
Figure 1 shows diagrammatically a compact development of buildings, divided into separate activity zones.

(i) *Wards for subnormal patients*

46. Here the planning requirement is that dormitories should be in groups separate from each other yet readily accessible to the central services. The age and sex of patients will determine primary divisions between groups of wards, while further subdivisions will distinguish between the classifications of patients. The needs of children are rather different from those of adults in that they will not be associated with the centralised activities for adults, but will be provided with their own self-contained group of school, training, and play accommodation.

47. Several ward units may be grouped around a courtyard or precinct. Roads and pathways to ward units (or groups of units) should be cul-de-sacs and branch off a main circulation route which may form a ring road for the residential zone or be used to separate one group of patients from another.

48. Because the general development will be compact the landscaping of spaces around and between buildings should be planned to provide complementary pleasant aspects from dormitory and day spaces, with maximum use of sunshine, and space for gardens and play areas where required.



Key:

A. Central Administration Core.

B. Rehabilitation, O.T. and Workshops, etc.

C. Social and Recreation Facilities.

D. Wards—for various groups of patients.

Figure 1. A self-contained psychiatric hospital (suitable for mentally subnormal patients). Diagram showing a compact development of buildings, divided into separate activity zones.

49. Ward accommodation for severely subnormal (non-ambulant) low grade patients and for (ambulant) medium and high grade patients will be described in detail in further Building Notes.

(ii) *Rehabilitation, training and workrooms for subnormal patients—general planning*

50. Buildings for these activities should occupy an 'industrial' zone within the hospital to which both in-patients and out-patients will need access. The buildings will mainly consist of separate training and work rooms. These rooms, although detached from each other (or planned in pairs) should all be linked by paths or covered ways to the staff offices for the occupational therapists, psychologists, technicians, etc.

51. Roads and pathways should relate this zone to the various ward groups as well as to the entrance to the hospital. Supply vehicles will need to approach each workroom.

52. The detailed planning considerations will be described in other Building Notes.

(iii) *Social and recreational facilities for subnormal patients*

53. This accommodation provides for a form of rehabilitation and will be considered in detail in a further Building Note. The site chosen for social and recreational facilities (other than playing fields, etc.) will be a focal point in the hospital to which all patients should have access. Although there will be diverse building elements in the social centre, such as multi-purpose hall, canteen, group meetings rooms, games rooms, etc., they should all be linked together in one complex. This should be versatile in use and be capable of adaptation and expansion.

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